



**CalPERS**  
**Member Services Division**  
P.O. Box 942717  
Sacramento, CA 94229-2717  
FAX (916) 795-0371

## DISABILITY ESTIMATE REQUEST

**(THIS FORM IS TO BE USED BY THE STATE EMPLOYER ONLY WHEN THE EMPLOYER  
WILL BE GENERATING A DISABILITY APPLICATION ON BEHALF OF THE MEMBER)**

**THIS FORM IS NOT AN APPLICATION FOR RETIREMENT.**

Please complete this form and fax or mail to the above address. The disability retirement estimate will be faxed or mailed to the address you indicate on this form. This estimate cannot be processed unless all information on this form is complete.

<b>1. Employee Name</b> (First) (MI) (Last)			<b>2. Social Security Number</b>	
<b>3. Employer Mailing Address</b>			<b>4. Member Birth Date</b> Month / Day / Year / /	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>5. Telephone Numbers</b> Work( ) Fax( )	
<b>6. Employer</b>				

<b>7. Last day on paid status</b> Month / Day / Year / /	<b>8. Type of Estimate</b> <input type="checkbox"/> Disability Retirement <input type="checkbox"/> Industrial Disability Retirement	
--	---	--

**9. Beneficiary Birth Date (if known)**

Month / Day / Year

/ /

Relationship to member: \_\_\_\_\_

A. Has the member been married or in a registered domestic partnership for at least one year prior to the retirement date?

☐ Yes

☐ No

B. Does the member have any unmarried children who are under age 18 or disabled?

☐ Yes

☐ No